Medicaid Infrastructure Grant

To Support the Competitive Employment of People with Disabilities

Questions and Answers

Section 203 of the Ticket to Work and Work Incentives Improvement Act of 1999 directs the Secretary of the Department of Health and Human Services (DHHS) to establish a grant program for the design, establishment, and operation of State infrastructures that provide items and services to support working individuals with disabilities. The Health Care Financing Administration (HCFA) is the designated DHHS agency with administrative responsibility for this grant program. The following provides answers to some frequently asked questions about the Medicaid Infrastructure Grant Program.

This document is not intended as a substitute for the grant solicitation itself, but simply provides additional details on selected topics. Answers are grouped into the following categories:

A. Who May Apply

A1. Is every State eligible for Infrastructure Grant funds or is a State required to apply for funding?

States must apply for Medicaid Infrastructure Grant funding. DHHS has issued a grant solicitation, which has details on how States can apply in order to be eligible for funding.

A2. Who is eligible to apply?

Either of the following may apply: (a) the Single State Medicaid Agency; or (b) any other agency or instrumentality of a State (as determined under State law) in partnership, agreement and active participation with the Single State Medicaid Agency, the State Legislature, or the Office of the Governor. For purposes of this grant program, "State" is defined as each of the 50 states, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

To be eligible, a State must meet the criteria established by HCFA for this grant program. There are four eligibility categories established under this grant. The four categories are: (1) Full Eligibility; (2) Conditional Eligibility; (3) Transitional Eligibility and; (4) Reserved Eligibility.

A3. Does a State have to provide Medicaid Buy-in coverage (e.g., for either the Basic Coverage Group or the Medical Improvement Group) to qualify for Infrastructure Grant funding?

No. States do not have to offer coverage under the Medicaid program to either of these two new TWWIIA categorically needy eligibility groups (or the BBA group) to be eligible for Infrastructure Grant funds. However, States are encouraged to use grant funds to educate potential beneficiaries about the new coverage options, and to assist in implementing the new groups if the State has elected to offer them.

A4. Is a State required to provide personal assistance services to people with disabilities to be eligible for funding?

The presence of personal assistance services under the Medicaid program (available to the extent necessary to enable individuals with disabilities to remain competitively employed) is a basic requirement that must be met for a State to receive grant funding. HCFA has attempted to make as inclusive an interpretation of this requirement as possible. Nevertheless, congressional intent requiring personal assistance services sufficient to support the competitive employment of people with disabilities is quite clear.

While HCFA has established multi-tiered eligibility criteria to include States with differing levels of personal assistance services, States are expected to improve the amount, duration and scope of their personal assistance services to advance within the multi-tiered eligibility criteria. The better a State's personal assistance service, the more opportunity the State will have both in terms of funding amount and duration of funding. See the section on personal assistance services in this document for more information.

A5. If HCFA determines that the personal assistance services offered by a State do not meet the criteria for the eligibility category applied for, does the State have to re-apply?

No, there is no penalty for "guessing wrong" with regard to which category applies. We will consider the application for the appropriate eligibility category. If additional information is necessary, a HCFA representative will contact the applicant's contact person. In your application you should simply (a) make the best case (with supporting evidence) regarding the current status of PAS in your State, and (b) make the best commitment you can with regard to what will be done to improve the adequacy and availability of personal assistance services. We will attempt to offer the best, appropriate response consistent with your improvement goals and congressional intent.

A6. What does HCFA require by asking States to work with the disability community as part of the Infrastructure Grant application and funding process?

An important criterion for rating the grant applications is the extent to which people with disabilities are actively engaged in both (a) the development and implementation of the grant proposal and (b) the ongoing design and implementation of work incentives efforts affected by the infrastructure grant. The methods of doing so are so varied that we do not restrict States by having specific requirements. We simply observe that the grant application process is a competitive one.

Many States have been exceptionally energetic in enlisting people with disabilities as drafters of applications, proposed legislation, administrative rules; as members of active advisory or review bodies; as members of appeal boards for the State's Medicaid buy-in program; as project or permanent employees for design or administration of their programs; as contractors for outreach efforts or other implementation efforts; as evaluators of program efforts; as key communications experts managing websites or PAS recruiters or schedulers; or as directors of their programs.

There are so many possibilities for innovative methods of engaging the talents of the disability community that our best suggestion is simply to brainstorm with people in your own disability and State communities.

Another suggestion relevant to this grant application is to involve people with disabilities in the development of specific, feasible actions the State can take to improve the adequacy and availability of personal assistance services in your State. These discussions can also supply some of the ideas needed for you to propose achievable benchmarks for improvement of PAS if you reside in a State qualifying as conditionally or transitionally eligible.

A7. To what extent do endorsement letters need to represent different divisions within our State agency, as opposed to just departments/agencies outside of our own department?

The best guide is common sense. Some States operate with very distinct and separate departments. Others use the "umbrella agency" approach. If you are in an umbrella agency and another component has significant responsibilities for a target group or for services or funding that will affect the extent to which the project succeeds, it is advisable to seek their endorsement.

B. Amount, Duration, Timing of Awards

B1. Can we apply for the grant and potentially qualify, even if we need State legislative approval for eligibility criteria funding?

Yes. HCFA is not requiring States to obtain legislative authorization to apply for infrastructure grant funding. If it is a State requirement that there be legislative approval before the State can receive grant funding, the State can still apply. If the State qualifies and State rules require legislation, HCFA will condition the grant award on the State obtaining the necessary legislative approval.

B2. Can a State request a specific amount and duration of Infrastructure Grant funding?

States can request a specific amount of funding. The minimum grant award for this first award cycle of 12 months is $500,000.

For most States, the minimum grant award will also be the maximum. The maximum amount a State may request is the greater of $500,000 for the grant period or 10% of the Medicaid buy-in expenditures for people with disabilities per year within specific parameters (up to $1.0 million for the first grant year for this group of newly eligible States and $1.5 million for subsequent grant years) and conditions.

With respect to duration of funding, States that qualify for full eligibility and conditional eligibility can request multi-year funding for up to a total of four years. States qualifying for transitional eligibility are only eligible for one year of funding. Those States qualifying for reserved eligibility have up to two years to receive funding, subject to the availability of such funds.

B3. Is annual improvement in personal assistance services required for a State to either qualify or apply for additional funding after the first grant year?

States that are *conditionally eligible* must meet annual benchmarks that have been agreed to by the State and HCFA in order to continue to receive funds after the first grant year. Multi-year funding, however, is assured for such States provided they have substantially met the benchmarks and other significant conditions of participation. The benchmarks must represent design changes that significantly improve the State's personal assistance services.

Transitionally eligible States may re-apply competitively for funding after the first year, provided personal assistance services are statewide and offered both inside and outside of the home by the end of the first year.

States with *reserved eligibility* have two years to get the required State support to qualify for the receipt of funds. Those States that do not garner the necessary support for improvement of personal assistance services by the end of year two may re-apply for reserved eligibility (or any other category for which they believe they qualify at that time).

B4. If we are selected for grant funding under the "Reserved Status" and later make PAS sufficiently available to qualify for release of funds, what is the earliest date that we could receive reimbursement for expenses?

Expenses within the scope of the approved grant application may be reimbursed as early as the first day of the grant year in which all conditions were met, including the actual availability of the necessary personal assistance services. For example, if evidence of PAS approval was submitted in June 2002, and the PAS became available and required conditions were met on December 1, 2002, expenses will be reimbursed back to the beginning of that grant year (January 1, 2002).

B5. Can a State re-apply for funding in the future if its previous grant award is unspent?

We are not inclined to grant subsequent competitive awards to States with existing awards unless they have expended or obligated most of the funds awarded to them under the previous award by the time we review new grant applications.

B6. What is acceptable documentation of buy-in expenditures that must be included with the initial application if a State seeks more funding than the minimum (i.e., seeks an amount based on their Medicaid buy-in expenditures) ?

States are required to document buy-in expenditures either in the form of expenditure reports

for the previous fiscal year or actual budgeted expenditure levels approved by the legislature and Governor for the previous year, the current year or the grant year. This documentation must be provided with the initial application. A State that has not yet implemented its approved buy-in, for example, could base its documentation on the fiscal estimate endorsed by the legislature when it enacted the buy-in legislation. A State that has implemented its buy-in could use either the approved budgeted levels or the annualized rate of actual expenditures.

We are being flexible because the buy-ins are relatively new and State's vary in their experiences. One State may have actual enrollment that is higher than the original fiscal estimate. We do not wish to penalize such a State for doing more than anticipated, hence we would permit actual rather than budgeted figures to be used. Another State may find that enrollment is proceeding more slowly than anticipated, but is building the infrastructure necessary to accommodate the larger enrollment which the legislature expects. In either case, we allow the State the more generous approach.

Evidence that is not acceptable is evidence that does not carry legal budgetary authority. For example, a fiscal estimate for a buy-in that has been submitted by the Governor for legislative consideration (but not approved) would not be admissible.

B7. If a State qualifies under the reserved level, at what point will the money (funds) be released? Is it at the transitionally eligible or the conditionally eligible level or somewhere in between?

Funds will not be released to States in the reserved eligibility category until the State demonstrates that personal assistance services capable of serving people with disabilities in competitive employment at the transitionally eligible level are available. Actual receipt of funding under this category is contingent on the availability of funds.

B8. If a State does not apply for some level of grant for infrastructure dollars, is the window of opportunity closed?

No. States that do not apply for a grant this year can apply in a future grant year. The infrastructure grant program was authorized in law for 11 years (beginning in FY 2001). Funding has been appropriated totaling $150 million for the first 5 years. Whether there will be funds left over in a particular fiscal year will depend upon the number of States, which apply and receive grants, and the amount of those grants. As a result, while HCFA anticipates some form of solicitation annually, competition for the grants will increase over time.

C. The Personal Assistance Services Requirement

C1. Do personal assistance services have to be provided statewide for a State to be eligible for Infrastructure Grant funding?

No. To qualify for full eligibility or conditional eligibility a State must provide personal assistance services in a statewide manner. Transitionally eligible States are not required to provide personal assistance services statewide at the beginning of the great year. However, transitionally eligible States must commit to transitioning their personal assistance services to statewide by the end of the grant period to be eligible for one year of funding.

C2. I get lost in all these "tiers" of State eligibility. What's the big message that I can tell my legislators?

The "big message" is:

- ✓ The federal government wants to help States enable people with disabilities to work.
- ✓ It is therefore (a) allowing States to sell Medicaid coverage to people with disabilities who work, (b) helping States improve the Medicaid services that assist people to work, and (c) enabling States to set up their own demonstrations to offer health coverage to additional working people with illnesses or impairments that might soon lead to disability and unemployment.
- ✓ The federal government is offering big bucks to States to help design and implement these initiatives. *Better yet, no State match is required for these grants.*
- ✓ To get one of these grants, the State must offer personal assistance services statewide – or at least commit to doing so in order to reserve funds for these grants.
- ✓ The better the State's personal assistance services, the more years the State can be funded (and hence the higher the overall funding the State receives).
- ✓ A State can increase its long term funding by making improvements to personal assistance services. Some key questions:
- ✓ Are PAS available statewide?
- ✓ Are they available outside the home with enough frequency and days/hours of coverage to enable employment (e.g. do they allow someone to get to and from work for weekday and weekend employment?

C3. If we don't know exactly whether we are a "conditional" or a "transitional" State, what should we do?

It is always advisable to consult with your HCFA regional staff. Our basic advice is:

- ✓ Make the best case possible (with supporting documentation) with regard to the category that you think best applies to you;
- ✓ Make your best commitment with regard to what will be done to improve the adequacy and availability of personal assistance services.

We will attempt to offer the best, appropriate response consistent with your improvement goals and congressional intent.

C4. Do personal assistance services have to be available, if needed, 24 hours a day, seven days a week for a State to be eligible for Infrastructure Grant funding?

No. Only fully eligible States are required to provide personal assistance services at times during both the day and night seven days a week, subject to a finding of individual need. This standard assures that people with disabilities who work non-traditional hours can receive services that support their employment.

C5. Are there specific requirements in terms of adequacy of personal assistance services in the different categories of State eligibility?

Yes. The overriding criteria is that personal assistance services support the competitive employment of people with disabilities. Major criteria include the scope of personal assistance services provided, the adequacy of personal assistance services and the progress made towards improvement of such services.

C6. If a state includes personal care as a Home and Community Based Waiver [Section 1915(c)] service (i.e. our State's personal care service of Consumer Directed Attendant Care), does this meet the criteria for "transitional"?

The fact that a State offers personal assistance services through a home and community based waiver does not, by itself, tell us enough to make a determination. The State would have to demonstrate that it provides a level of personal assistance services that is adequate to support the competitive employment of people with disabilities. This would include providing the services inside and outside of the home and for an appropriate number of hours sufficient to accommodate people with disabilities who work. A State considered transitionally eligible would have until the end of the grant year to provide personal assistance services statewide and inside and outside of the home to be eligible for one year of funding. States seeking transitional eligibility must provide HCFA with a letter of commitment outlining how the requirement of statewide provision of personal assistance services inside and outside of the home will be achieved by the end of the year.

C7. What is "competitive employment?"

To be eligible for funding, a State's personal assistance services must support the competitive employment of people with disabilities. Competitive employment is defined in the Infrastructure Grant as work—

(i) In the competitive labor market that is performed on a full-time or part-time basis in an

integrated setting; and
(ii) For which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled.

The personal assistance services offered by a State must support competitive employment of disabled individuals that takes place either in the home or in an integrated work setting. An integrated work setting means a setting typically found in the community in which employed disabled individuals interact with non-disabled individuals, other than the non-disabled individuals who are providing the employment service.

C8. How will HCFA evaluate whether a State's personal assistance services are sufficient to support competitive employment of at least 40 hours per month in assessing conditional and transitional eligibility?

HCFA's evaluation will be based on information regarding the personal assistance services package offered in the State to people with disabilities submitted by each State with the application for Infrastructure Grant funding. Such personal assistance services are not expected to meet all of the criteria set forth in Appendix One, but are expected to be provided in such a manner that they meaningfully impact the ability of people with disabilities to obtain and sustain competitive employment. For instance, personal assistance services limited to one hour per day (regardless of the amount the person actually requires) would not be sufficient to meet this criteria.

By the terms "sufficient to support competitive employment of at least 40 hours per month," we do not necessarily mean to imply that people would require 40 hours of personal assistance services. A particular individual working 40 hours per month might only require only 9 hours of personal assistance to arise in the morning two days per week, get ready for work, and get to the job site. The job site might even be the person's own home.

The key principle is that the amount of personal assistance services a person receives ought to be governed by an assessment of the individuals' circumstances, condition, and those solicited desires that they are willing to act on themselves. Employment is an example of one such desire. It is a desire that will often remain unrealized unless adequate personal assistance is available.

The key concept is that the amount (and location) of personal assistance required is an individual determination, varied by the individual factors described above. This means that arbitrary caps on the amount of service, specified from afar, specified without actual knowledge of an individual, and unconditioned by exception based on an individual's requirements and the system's desire to know, is untenable.

C9. Does a State that only provides personal assistance services in the home have to expand to providing such services outside the home to be eligible for Infrastructure

Grant funding?

For multi-year funding, yes. For one year of funding, no. Eligibility for funding for one year is not contingent upon services being provided outside the home. States can apply under the Transitional or Reserved eligibility and be eligible for funding; however, receipt of funding is contingent upon a State expanding services to outside the home.

Transitionally eligible States are not required to provide personal assistance services outside of the home at the beginning of the grant year. However, they must commit to transitioning their personal assistance services to outside the home by the end of the grant period to receive 1 year of funding.

States with Reserved eligibility are not required to provide personal assistance services outside of the home, but must take affirmative steps towards doing so within 2 years of the date of grant application.

C10. Describe "statewideness" relative to PAS for transitional & reserved grants. Is this statewide by "people condition" (i.e.: disability specific) or geographic?

Transitionally eligible States are not required to provide personal assistance services statewide at the beginning of the grant year. However, transitionally eligible States must commit to transitioning their personal assistance services to statewide by the end of the grant period to be eligible for one year of funding.

States with reserved eligibility are not required to provide personal assistance services statewide, but must take affirmative steps towards obtaining the requisite legislative approval necessary to offer such services statewide within two years of the date of grant application.

C11. Could a state provide the personal care services through a Medicaid HMO contractor willing to offer personal care services in an expanded fashion beyond the state plan level?

Yes. However, if the authority under which the state conducts the managed care service is one which calls for voluntary enrollment, then the State must have a method of providing the PAS services to people who choose not to enroll with the HMO in order to qualify as a "fully eligible" State.

C12. PAS/Personal Care in our State seems very limited. If it is a State Plan Medicaid service, and we implement a Medicaid buy-in, will people who buy-in be able to access personal care? Is that or can that be part of what they buy into?

If an individual is eligible for Medicaid under one of the work incentives eligibility groups, he or she is entitled to receive any or all of the services provided under the State Medicaid plan. If

the State covers PAS as a plan service, individuals eligible under the work incentives groups can access those services. If a State amends its HCBS waiver to include people whose eligibility is established under the Medicaid buy-in, such individuals will also be able to access HCBS services.

C13. I am concerned about people who receive PAS from HCBS waivers. These waivers require that people meet the level of care required for admission to a nursing facility or other institution. When that participant engages in more and more work, at some point he/she will no longer meet an institutional level of care which is necessary to maintain waiver eligibility, and possibly Medicaid eligibility for that participant. Does the TWWIIA legislation permit continuation of such a person's waiver and/or Medicaid eligibility? This is similar to persons who lose Medicaid coverage due to medical improvement.

The TWWIIA legislation enables States to provide Medicaid to persons with disabilities who want to work regardless of increases in their level of earnings. Thus, a working disabled person can continue to receive basic Medicaid services as his or her earnings increase.

Eligibility for services under an HCBS waiver is based on two considerations: (a) the person is Medicaid eligible using the broader institutional eligibility rules, and (b) the individual requires a level of care typically provided in an institution.

Eligibility under a home and community-based services waiver is not based on disability status, but on the medical need for institutionalization, in the absence of waiver services. Any aspects of a State's assessment protocol for level of care that touches upon a person's employment (or unemployment) should be promptly removed. Level of care required is a consideration entirely distinct from location of care.

Given these considerations, it is inconceivable that a HCBS participant who returns to work (or gains employment) would place him or herself in jeopardy of losing HCBS eligibility by this act alone. If you learn of any circumstance in which such a result appears possible, please let us know immediately.

C14. Must there be a prior authorization for State Plan PAS services?

There are no Federal requirements for prior authorization for PAS services. However, States have the option of requiring prior authorization for those services, just as they can require prior authorization for most other services covered under their Medicaid programs.

C15. Many consumers accessing or who would qualify for personal assistance services would also qualify for intermittent home health services (at home). How is it determined which program to access?

Whether a person in the situation described would receive PAS or home health services, or both, depends on how a State has structured its program. There is nothing to inherently preclude a person from receiving both PAS and home health services, and in fact some States provide PAS through their home health programs. Other States that provide both PAS and home health services have chosen to limit individuals to one service or the other, but not both at the same time.

C16. Do you have guidelines on how to establish benchmarks for PAS under conditional eligibility? (beyond knowing that this requires input from the disability community)

HCFA's operational definition of an effective personal assistance service contained in Appendix One of the solicitation sets forth the best framework for a conditionally eligible State to use in developing benchmarks. Conditionally eligible States that move closer to meeting the criteria in Appendix One have a greater chance of qualifying for full eligibility.

In other words, examine what a fully effective system would look like and imagine the stepping stones that would get your State from where it is now to a more adequate system. For example, if your State does not now offer PAS outside the home, a next logical step would be to offer PAS from the home to the work site location (i.e. access to needed transportation services). That would be one benchmark. Another benchmark would be to offer PAS inside the work site although, frankly, this turns out to be only minimally necessary in most cases. What may be more necessary once someone is inside the work site is crisis intervention, case management assistance to access generically available services, episodic help to access reasonable accommodations that employers or VR should provide, etc.

C17. What does it mean to offer personal assistance services statewide?

Statewideness is a requirement of the Medicaid statute and a basic principle of the Medicaid State plan program. It assures that all individuals who meet the eligibility criteria for the program, no matter where in the State they reside, have access to the same services. (See answer to C1.) Statewideness does not require that providers who offer the service be available throughout the State, as long as all eligible individuals in the State can receive the service from a provider.

Statewideness, as it relates to TWWIIA is an important criterion that will be used for awarding infrastructure grants. For example, having a statewide PAS program in place at the time of application is an eligibility criterion for Full or Conditional eligibility, but not for Transitional eligibility which requires eligible States to commit to transitioning their personal assistance services to statewide by the end of the grant period. All States are expected, however, to either have a statewide program in operation or show commitment to a statewide program, in accordance with Medicaid State plan requirements in order to re-apply and be eligible for further infrastructure funding, contingent upon the availability of funds on a competitive basis.

C18. We are talking about PAS being available "statewide." Don't we really mean that PAS services must be available "comparably" to all disabled people who need them? If we say this, then how do we define this in the State plan?

Statewideness and comparability are two different Medicaid State plan program requirements. As discussed in C1 and C10, statewideness requires that State plan services be offered to individuals throughout the State. However, when we talk about PAS being available comparably to all disabled people who need them we mean that once a State defines its PAS program, comparability requires that all eligible individuals to whom the service is useful, regardless of which condition they have, be given the opportunity to receive the same amount, duration, and scope of the service.

States seeking to define PAS in their State plans should be mindful that in order to qualify for the infrastructure grant program, services must be made available in a manner that conforms with Medicaid State plan requirements and the intent of the Ticket to Work and Work Incentives Improvement Act of 1999 which aims to promote and support the competitive employment of people with disabilities by making PAS available to all disabled people who need services inside, as well as outside, their homes in order to sustain competitive employment.

C19. Do we have to make these unlimited PAS to all Medicaid Beneficiaries? Is there a way to make PAS available to people 16-65 in amount, duration, and scope required by the infrastructure grant to become fully eligible.

The answer to this question goes back to the answer in C12 above regarding comparability provisions in Medicaid State plan programs. States are required to provide State plan services to all eligible individuals to whom a service is useful. And, while States have the flexibility under optional State plan benefits to narrowly define services based upon, for example, medical needs criteria, it cannot limit services based upon age. Comparability requirements preclude States from providing services to some recipients and excluding others who would benefit from the service based strictly upon age.

C20. Are there provisions in the State Medicaid Manual allowing States to limit those eligible for State plan PAS? (i.e., to only those working?) In particular, can personal assistance/attendant services be limited to persons working at least 40 hours per month or at various thresholds as recommended by the State?

While there are no provisions in the State Medicaid Manual that allow States to limit PAS to only those working, the basic premise of Medicaid law permits States flexibility in defining optional services under the Medicaid State plan program. It is not unreasonable for a State to define an optional benefit so that it limits services to those who meet a level of care determined

by the State.

C21. Will personal assistance (attendant) services be considered medically necessary regardless of location, i.e. home or job? (Example: prescribed by physician)

Yes. An individual's need for PAS is documented based on medical necessity criteria established by the State and an individual medical assessment to determine the scope of those needs. Once medical necessity and needs are determined, PAS should be available in an amount necessary to support the individual, regardless of location.

C22. Will greater license be given to non-medical staff to "prescribe" personal assistance services as needed to maintain employment for these individuals?

Federal regulations require State plan personal care (assistance) services be authorized for an individual by a physician in accordance with a plan of treatment, or (at the option of the State), authorized in accordance with a service plan approved by the State. While a State may use it's own discretion as to whether it "permits" non-medical staff (e.g., personal care attendants) to recommend or make suggestions about an individual's care plan, Federal law does not permit non-medical staff to "prescribe" personal assistance services.

C23. If a State establishes a personal assistance services program for individuals who are engaged or have the opportunity to engage in competitive employment, will the State be required to provide those services to any individual who qualifies for Medicaid and who needs personal assistance services?

The State is not required to provide PAS to any individual who qualifies for Medicaid and who needs PAS. However, once the State defines the service in terms of level of need, it is required to provide PAS to all eligible individuals who meet that need.

C24. Is a State eligible for grant funding if it has caps on the number of days or the number of hours per day that personal assistance services are available to people with disabilities?

States are eligible to apply for Grant funding as either Conditionally Eligible or Transitionally Eligible as long as personal assistance services are available at least 40 hours per month. Over the course of time, States with Conditional or Transitional eligibility are expected to meet benchmarks indicating the transition of their personal assistance services program in a manner that moves them closer toward qualifying for full eligibility. Full eligibility is achieved once a State demonstrates a PAS program that is statewide, available 7 days a week, day or night if needed, and capable of supporting full time competitive employment of disabled individuals.

C25. It appears that the infrastructure grant is targeted for expenditures to move personal care to a <u>broader</u> population of folks returning to work than our State now

covers. Is it only those returning or across the board?

Section 203 of TWWIIA allows grants to States to support the design, establishment and operation of State infrastructures that provide items and services to support working individuals with disabilities. States receive grants once they demonstrate that they make PAS available under the State plan to the extent necessary to enable individuals with disabilities to remain employed.

The requirement of section 203(b)(2)(A) applies to working disabled; i.e., "the extent necessary to enable individuals with disabilities to remain employed." It does not apply to disabled individuals who are not working. While PAS cannot be targeted only to disabled individuals who are working, PAS does not have to cover all disabled individuals.

C26. Can PAS State Plan services be provided on a sliding-fee scale? Does Medicaid allow?

We are not clear on what this question is really asking but we believe there are two possible interpretations, both of which are addressed below.

(1) The question may be whether PAS State Plan services are subject to payment of a premium or other cost-sharing charges, which are set on a sliding scale based on income, under one of the work incentives eligibility groups. The answer is, collection of premiums or cost-sharing charges is limited to individuals who are eligible for Medicaid under one of the work incentives groups. Further, the amounts of premiums or cost-sharing charges, and whether eligible individuals will be required to pay such amounts at all, is essentially up to each State. A State could require payment of cost-sharing for services, including personal assistance services, provided to a work incentives-eligible individual, but authority to do so is essentially limited to the work incentives groups.

(2) Alternatively, the question may be whether reimbursement can be made for PAS based on some sort of a sliding-fee scale. The answer to that question is, States may make payments to providers according to the "degree of difficulty" which the service represents. For example, a person with a relatively low level of disability may require only a few services, while a person with a higher level of disability may require a greater number of services. Services provided to the person with a higher level of disability can be reimbursed at a higher rate based on the greater number and complexity of the services the person may need. States may also choose to reimburse providers at higher rates based on their willingness to provide services in geographically underserved areas of the State. However, identical levels of services cannot be reimbursed at different rates based, for example, on whether one person has more income than another.

C27. If a State has submitted a 1915 (c) waiver to enhance its personal assistance services benefit and it has been received by HCFA by the end of the grant year but is

not yet approved, does the State meet the criteria for transitional eligibility? Reserved eligibility?

A waiver application that has been received but is not yet approved will not qualify a State for transitional eligibility. Only approved waivers can qualify a State for transitional status. However, we will do our utmost to act on waiver requests that may affect a State's eligibility for grant funds as expeditiously as possible, as we do for all section 1915(c) waiver applications. In terms of timing, federal law requires HCFA to act on section 1915(c) waiver requests within 90 days unless additional information is needed, in which case the law provides for an additional 90-day period once the additional information is received. We will make every effort to act on waiver applications as early in that timeframe as possible.

D. Uses of Funds

D1. Can a State use Infrastructure Grant funds to provide services under the Medicaid program to people with disabilities?

Infrastructure grant funds may not be used to provide direct services, but may be used for developing the capacity to provide items and services needed by employed people with disabilities. Prime examples are the staffing and systems necessary to offer the new Medicaid eligibility groups, improve key State Plan services such as personal care, or design and prepare for the Demonstration to Maintain Independence and Employment (for more information about the Demonstration **click here**). This could include outreach, planning, designing, or implementation of Medicaid coverage options under the TWWIIA. Staffing at State agencies or under contract would also be a permissible use of funds. The infrastructure grants could not be used to provide personal care directly, and could not be used as a substitute for a personal care option under Medicaid.

D2. Can a State use Infrastructure Grant funds to support services other than those listed in the solicitation?

Yes. The TWWIIA provides infrastructure grant funds to States for a variety of purposes, such as: (a) implementing or improving the new Medicaid eligibility groups, (b) designing or implementing improvements in the State's Medicaid plan for those services which support people with disabilities in their employment endeavors, such as personal care, transportation, assistive communication devices, community mental health services, etc., or (c) designing and initially implementing the Demonstration to Maintain Independence and Employment.

However, this list is not intended to be exhaustive. Provided the funds are not used for direct services, States have significant flexibility. For instance, staffing and reasonable informational infrastructure are permissible uses of funding. The staffing could support initial implementation of system improvements, subject to a phasing out of the grant funds and gradual assumption of any on-going administration via the regular State Medicaid administrative funding or other monies.

D3. Can grant funds be used to provide transportation services for buy-in participants?

No, transportation would be a direct service and as such would be impermissible as a grant funded activity except on an emergency basis. Except for those emergencies, Infrastructure Grant funds cannot be used for the direct provision of services to people with disabilities. Using infrastructure funds to pay a provider of transportation services for a person covered under either of the new TWWIIA categorically needy Medicaid eligibility categories (often referred to as the buy-ins) qualifies as using infrastructure grant funds for a direct service. Therefore such use is not permissible.

The one instance when it is permissible to use infrastructure grant funds for a direct service is where, as a last resort, emergency expenditure is necessary to sustain an individual's competitive employment. An emergency use is defined in the grant solicitation to include an intervention or support enduring no more than one day which is designed to compensate for the unexpected breakdown of the person's normal support system and for which other resources are not readily available to sustain a person's employment schedule or commitments. Coverage for transportation breakdown in such a circumstance would be permissible. Emergency PAS would be another. Emergency provision of day care for a worker's children would be a third example.

Finally, it is permissible to use infrastructure grant funds to establish the capability to provide emergency response services that would compensate for the breakdown of an individual's normal support system. This could include time-limited start-up funding for such a service.

D4. Infrastructure Grants under Buy-In Design and Implementation talks about staffing or contract costs and management. Management implies longer-term activities. Can funds be used to maintain the management of premium collections over the life of the grant, for example? Or to maintain the availability of specialist positions to support the work of eligibility workers (someone they can turn to for answers to questions about employment services & supports and who provides training and technical assistance to them over the life of the grant)?

Using infrastructure grant funding to support staff whose function it is to collect premiums for the new eligibility groups is permissible insofar as these activities are also permissible under Medicaid as an administrative expense, it is required that grant funding for such an activity be

phased out during the grant period and assumed as a regular Medicaid function. For one-year transitional grants this is not an issue; but for States seeking multi-year funding the grant award will be conditioned upon such a gradual assumption of this administrative responsibility as part of the normal Medicaid program.

Infrastructure grant funding can also be used to fund specialist positions whose job it is to provide training and technical assistance to eligibility workers regarding issues such as how to determine whether individuals meet the criteria of either or both of the new eligibility groups (i.e. whether an individual meets the criteria necessary to qualify for eligibility based on medical improvement) and the kind of employment services and supports that are available to workers with disabilities or those with medically improved conditions. Such a role (TA to eligibility workers) is distinct from benefit counselors who provide counseling to individuals with disabilities and which is a proper VR services, or a special project under an SSA benefit specialist grant, or even Medicaid case management.

D5. For individuals with severe mental illness, supported employment has been demonstrated to be effective in obtaining and maintaining work. Short term funding for supported employment services are available through the State VR system. However, VR is prohibited from providing this on a long-term basis. Generally, VR closes a case 60-90 days after competitive employment has been achieved. What can we do?

First, there is more flexibility under the VR system than has traditionally been the case. Explore with your VR agency some of the new possibilities in your new partnership arrangement. At a minimum, VR has the option to provide crisis intervention. VR is the agency charged with responsibility to achieve employment outcomes. As the State Medicaid Agency, you hold one of the keys to success: new ways to guarantee health coverage while working. You also offer considerable support for the continued success of the person's employment, insofar as the State Medicaid Plan (and HCBS waivers) provide key services that offer individuals the possibility of on-going support for their employment endeavors.

It is worth noting that VR agencies receive a special and substantial payment from the Social Security Administration for SSDI beneficiaries who return to work and earn above the "substantial gainful activity level" for any random nine months in a five-year period. Such monies do not require State or local matching funds and may be applied back into the provision of VR services outside of normal federal VR regulations. The new Ticket to Work legislation provides additional reasons for a VR agency to offer longer term supports. Under the Ticket, an agency (public or private) selected by the individual may receive special payments if the individual returns to work at the SGA level. The payments can continue for up to five years, *so long as the individual continues working.*

D6. Can you limit the number of people who you serve under the infrastructure grant?

This question may reflect a misunderstanding of the Infrastructure Grants. As explained in the answer to D1, infrastructure grant funds cannot be used for the provision of direct services to people with disabilities, except on an emergency basis. The goal of the Infrastructure Grant program is to help build the capability of the State's system to support people with disabilities in securing and sustaining competitive employment in an integrated setting.

If the question here is "may a State limit the number of people who may receive emergency services from the Infrastructure Grant, or may a State establish a fixed budget of Infrastructure Grant Funds that will be devoted to emergencies," then the answer is "yes."

The Infrastructure Grants are entirely different from the Demonstration to Maintain Independence. The latter does indeed offer direct services. The Demonstration is used by States to provide Medicaid-equivalent benefits to targeted participants with a specific potentially disabling condition. Under the Demonstration to Maintain Independence, a state may indeed limit the number of participants. See the separate grant solicitation for the Demonstration.

D7. May unspent grant money be carried over from one grant year to another?

Yes. States receiving awards may retain grant funds until they are expended, subject to any conditions of the grant itself.

D8. Will health care outreach and access infrastructure projects using the web as the delivery medium be considered? Web initiatives could significantly increase health care access for people with disabilities and may, as a secondary outcome, assist other populations.

Yes. This could be a particularly effective form of outreach for certain target groups.

D9. For persons with mental illness, what types of employment supports is HCFA now saying can be included in a State plan? Can, for example, the ongoing support services (post VR) be included and can we use the infrastructure funds to help plan, design, manage and evaluate these changes? Can you give examples of other States that have done this through their mental health State plan or waivers?

Employment support services such as vocational rehabilitation and job training (usually provided under 1915(c) waivers) are not covered services under the State plan, except for under the ICR/MR benefit. Services coverable under the State plan that support persons with MI can include psychosocial rehabilitation services such as restoration of basic living skills necessary to independently function in the community (e.g., mobility skills, communication/socialization skills and techniques, and community awareness). Counseling and therapy services directed toward the elimination of psychosocial barriers that impede the development or modification of skills necessary for independent function in the community also are covered State plan services. States have a great deal of flexibility under their State plan for the provision of these services.

A managed care waiver (s.1915(b)) or a research and demonstration waiver under s. 1115 may also be used to provide added flexibility. However, both of these waivers are subject to a cost-neutrality test. This means that if you expect to pay for things that Medicaid typically does not provide, you would need to be able to demonstrate offsetting savings in other Medicaid services. These waivers also require considerable investment in planning and service delivery. Infrastructure grant funding could assist you in such planning and development. If you wish to pursue such an option, we would be pleased to discuss the possibilities with you.

E. The Medicaid Buy-In

E1. How can a State structure the buy-in so that, once a disabled person buys in, the person does not lose HCBS waiver services by virtue of being over-income?

The question really is how the State can structure its HCBS waiver to ensure that persons eligible under a work incentives group can receive waiver services. This can be done by either amending an existing waiver, or applying to HCFA for approval of a new waiver, to cover the work incentives group under the waiver. Once the work incentives group is covered under a waiver, a person can receive HCBS waiver services as long as he or she continues to be eligible for Medicaid under the work incentives group.

E2. Under the grant, must all disabled working persons, as determined by SSA criteria, be included for Medicaid coverage? If not, may the State limit the program to specific disability groups?

This question more properly belongs to the Medicaid buy-in or the Demonstration to Maintain Independence. As explained in an earlier question, infrastructure grant funds cannot be used for the provision of direct services to people with disabilities, except on an emergency basis.

This limitation sets the Infrastructure Grants apart from the Demonstration to Maintain Independence because States can use the Demonstration to provide Medicaid-equivalent direct services to targeted participants with a specific potentially disabling condition.

E3. Concerning disability determinations, can the State designate an entity other than the Social Security Administration to perform disability determinations? If so, under what circumstances and special conditions?

The State may designate another agency. However, the same protocols must be used

statewide. For the Medicaid Buy-in these protocols must match the SSA protocols (except for people covered under a Medical Improvement option selected by the State.)

For the Demonstration to Maintain Independence, the protocols would of course be different from SSA's and would be designed by the State and approved by HCFA.

E4. The BBA (or TWWIIA) group can have higher resource levels than the $2000/$3000. What happens to that person who has accumulated higher assets when they retire? Also, with the earnings, comes the potential for higher retirement income & that too may make them ineligible?

A person who is fully retired admittedly is likely to lose Medicaid if the person could qualify only under one of the work incentives groups. Eligibility could be lost for a variety of reasons, including the person no longer being employed, or having too many resources, or too much unearned income because he or she is receiving a pension, to qualify. Some of these problems may be avoidable; for example, the person may continue to be employed in some capacity, even if his or her work effort is reduced from the level before retirement.

However, it must be emphasized that the work incentives groups under both the BBA and TWWIIA are designed to assist individuals with disabilities who want to work. The work incentives groups were never intended to provide Medicaid to a person indefinitely regardless of whether that person continues to meet the requirements for eligibility under the program.

E5. How is a recipient covered by a HCBS waiver affected by TWWIIA?

As explained previously, a State can provide HCBS waiver services to persons eligible under one or both of the TWWIIA groups by amending an existing waiver, or applying to HCFA for approval of a new waiver, to cover the group or groups under the waiver.

E6. Can the state limit the buy-in option to persons working at least 40 hours per month? Can the State limit the options to persons working at least 40 hours per month but less than 80 hours per month or any other monthly work threshold?

While States must require that applicants have earnings in order to establish eligibility for the Medicaid Buy-in, there is no provision of the law which permits States to establish minimum thresholds on the amount of hours a person must work in order to be eligible.

E7. Can the buy-in be limited to individuals with no other insurance coverage or available coverage? (Example: Medicare eligibles)

No. You may require that individuals access available private insurance coverage (including Medicare) so long as Medicaid pays the premiums and cost-sharing. However, there is no

authority under the Medicaid statute to restrict eligibility for any of the work incentives groups to individuals with no other health insurance. If an individual has other health insurance, Medicaid would become wrap-around coverage that would only pay for those services the individual's medical insurance does not cover.

E8. What is the recommended length of time for transitional coverage/eligibility for a previously covered person within the categorical group should he/she lose their job?

HCFA has no recommendations to make on this subject.

E9. How will the SSA consider disability income (SGA) for those persons between the age of 16-18?

The basic rules for considering income earned by a disabled individual are the same regardless of the individual's age. Under the BBA group, all earned income is disregarded in determining eligibility. Also, the SGA limit of $700 a month must be ignored in determining whether the individual is disabled. Under the TWWIIA work incentives groups States may, but are not required to, disregard earned income beyond the standard SSI earned income disregard in determining eligibility. However, as with the BBA group the SGA limit must be ignored in determining whether the individual is disabled.

F. Dissemination and Learning Requirements

F1. Can a State meet its obligation under the "Dissemination and Learning" evaluation criteria by participating in a State-to-State Medicaid Infrastructure Partnership?

A State may receive points under the Dissemination and Learning evaluation criteria by participating in a State-to-State Medicaid Infrastructure Partnership. The number of points given to the State will depend upon the degree to which the State's participation in the State-to-State Medicaid Infrastructure Partnership satisfies the Dissemination and Learning criteria of evaluation. Thus, States that show how their participation in the State-to-State Medicaid Infrastructure Partnership meets these criteria of evaluation will receive a higher rating under Dissemination and Learning than other States which do not reveal how their involvement in the State-to-State Medicaid Infrastructure Partnership addresses the Dissemination and Learning criteria of evaluation.

G. State to State Infrastructure Partnerships

G1. Why is HCFA so interested in States helping each other through things like the "State to State Medicaid Infrastructure Partnerships?"

Because:

(a) This work is important and, we believe, will form the basis for further developments in the field of disability policy.
(b) Many States lack the core planning capability around which to build a true work incentives initiative. Securing help from other States may be a way of engendering such initial capability.
(c) We are collectively in the process of inventing new ways to be effective – effective in helping employers tap into the talent pool of people with disabilities; effective in helping people with disabilities achieve valued social and economic roles in our communities; and effective in how our services can best achieve the results intended. We will not succeed without a continuous and shared learning from our experiences.
(d) States and the disability community will be in the best position to see the improvements needed and help each other.
(e) We wish to climb the learning curve as quickly and as efficiently as possible. Close communication, mutual technical assistance, and a learned sharing of experiences and techniques represent effective ways to accomplish continuous improvement, as well as avoid costly misadventures.

We believe that a national infrastructure comprised of representative leaders from among the States and disability communities will be one of the most effective ways to achieve the infrastructure goals of TWWIIA.

G2. Which States are required to establish or participate in a State-to-State Medicaid Infrastructure Partnership?

All States are expected to undertake learning and dissemination activities (see grant solicitation, Review Criteria).

Fully and conditionally eligible States (as well as those receiving more than the minimum grant award) are required to provide or contribute to some form of technical assistance specifically to other States. Please refer to the grant solicitation, section III D paragraph 4. For States receiving more than the minimum award, the extent of funding will be affected by the plans to provide technical assistance and organize learning into tools useful to other States.

G3. May a State serve as a resource to other states if it meets the personal care

services requirements but has not yet enacted and implemented its Medicaid Buy-in Program? If so, are the dollars for becoming a resource in addition to the State grant?

Certainly. As observed previously, all States that submit grant proposals will be evaluated, to some extent, on the degree to which the State plans to share its knowledge and experiences in supporting the competitive employment of adults with disabilities with other States.

G4. Will we receive more money if we participate in or form a State-to-State Infrastructure Partnership?

Grant awards for States eligible for more than the minimum amount will be affected by the extent to which the State provides technical assistance to other States. For States eligible to receive the minimum award, the grant amount would neither increase nor decrease. However, participation with other States in an Infrastructure Partnership is one way of increasing the State's ability to meet the dissemination and earning requirement of the grant (see rating criteria in the grant solicitation).

G5. How many Partnerships do you hope for?

We will accept more than one Partnership. It is apparent that (a) States learn best from each other and (b) States emulate and identify most closely with other States they perceive to be most like them. These observations lead us to conclude we should be open to more than one Partnership representing different political and economic cultures. On the other hand, there are certainly economies of scale in a larger Partnership and increases in overall capability.

G6. Can a State or State instrumentality (such as a State university) submit a separate proposal for a technical assistance partnership?

Yes. The technical assistance component may be made into a separate application. This is the only exception made in the grant solicitation to the "one application per state" policy. (see grant solicitation section III. A Paragraph 1).

We appreciate that separating this out into a distinct proposal may be administratively easier and may allow a clearer presentation, but creating two proposals or consolidating them into one proposal will not by itself increase or decrease the overall amount of funding available.

A separate application for a State-to-State Infrastructure Partnership, or for the State Dissemination and Learning Component, may be submitted by another State agency (such as the University) provided:

(a) The application has the endorsement and active participation of the Single State Medicaid Agency, the State Legislature or the Office of the Governor;

(b) The technical assistance program makes "significant use of staff administering State programs affecting work incentives improvement" (see grant solicitation section III. D. 4)

If a State wants to separate out its dissemination and learning component (or its proposal for a State-to-State Medicaid Infrastructure Partnership) into a distinct application, the combined budget total will still be subject to the overall spending limits for each participating State.

States may combine their allocations into a common endeavor, however, as the following questions indicate.

G7. Will HCFA accept a consortium of States working together for purposes of forming a State-to-State Medicaid Infrastructure Partnership?

Yes. HCFA will accept a consortium of States working together for purposes of forming a State-to-State Medicaid Infrastructure Partnership. In such a case we would expect each State to indicate the amount of funding it will assign or subcontract to the consortium.

G8. Does a State need to establish a new Partnership or are there existing Partnerships that a State can participate in?

A State can either establish a new Partnership or participate in an existing Partnership if that Partnership is open to accepting additional States. Additional information about existing Partnerships will be posted on the TWWIIA website (www.hcfa.gov/medicaid/twwiia/twwiiahp.htm) at a future date.

G9. Does every State participating in a Partnership need to submit a separate proposal or narrative for technical assistance?

No. The organizing entity can submit a single narrative that describes the consolidated activities of all members of the Partnership. Each member State, in its own application, can simply refer to the consolidated proposal and indicate the total amount of funds and support that the State is contributing to the Partnership. For example, the State might simply note: "Our obligation for learning and dissemination is fulfilled by our participation in X partnership and commitment of $X and X FTE to that Partnership, as described in the proposal submitted by _____."

H. Miscellaneous

H1. What is HCFA doing to model for the States relationships with the SSA & DOL and the overlapping issues related to eligibility, vocational rehabilitation, etc.?

The President's Task force on Employment of People with Disabilities is one example that could be emulated at the State level. Federally, the Task Force has been an excellent vehicle, backed by executive authority, to bring federal agencies together in a common endeavor that is bigger than any one of us.

At HCFA, SSA, Department of Labor, and the Rehabilitation Services Administration we trying to coordinate our grant–making and TWWIIA administrative activities so they reinforce each other without overlapping. We hope the combined effort will be one that enables States to put together a more powerful, comprehensive plan for employment of people with disabilities. We are not there yet, and appreciate any suggestions you may have.

H2. How could a disabled resident or HCFA/SSA employee become a part of the Disability Task Force in our State to work with State offices on shaping this legislation (TWWIIA)? Who can we contact regarding this?

Disabled residents or Federal employees should contact the task force in your State directly. Also, the State Medicaid agency may have information about the task force. Another alternative in New York State would be to contact a Center for Independent Living. However, it should be noted that there may be restrictions on whether a Federal employee can serve on such a task force, depending on the person's duties and responsibilities as an employee of the Federal government.

H3. On page 4, paragraph 3, do we need to concern ourselves with the issue of someone <u>relocating</u> to another State? (implications for employment & different State Medicaid administered health coverage programs).

No. Under the Medicaid statute a person, for the most part, cannot be eligible to receive Medicaid services in a State unless the person is a resident of that State. Thus, States are not required to consider the services offered in other States or in neighboring States when applying for infrastructure grant funding.